

**Viral/Aseptic Meningitis/Encephalitis/Meningoencephalitis Report Form**

If you have any questions concerning the information requested on this form,  
please contact the Office of Epidemiology at (801) 538-6191

**Patient Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex ☐ M ☐ F **Date of Report** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_

State \_\_\_\_\_ ZipCode \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_

Race ☐ White ☐ Black ☐ Am Indian/Alaskan ☐ Asian ☐ Other Hispanic: ☐ Yes ☐ No**Clinical Information**Hospitalized? ☐ Yes ☐ No Did the patient die of this illness? ☐ Yes ☐ No ☐ Unknown

Hospital Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

AdmissionDate \_\_\_\_\_ Date of Onset \_\_\_\_\_ Date First Neurologic Symptom \_\_\_\_\_

Diagnosis ☐ Encephalitis ☐ Meningoencephalitis **Meningitis:** ☐ Viral ☐ Aseptic ☐ Other**Medical History**

Has the patient been vaccinated for or had a prior history of:

☐ Yellow Fever ☐ Japanese Encephalitis ☐ Dengue Fever ☐ St. Louis Encephalitis☐ Other arbovirus or flavivirus (please specify): \_\_\_\_\_

Specimens Collected	Date Collected	Type of Test	Result	Etiologic Agent

**Travel History**

Travel during the two (2) months before onset of illness:

Date	City	State	Country

**Requesting Physician**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Work Address \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell \_\_\_\_\_ Pager \_\_\_\_\_

**Submitted by:** \_\_\_\_\_**Agency:** \_\_\_\_\_**Phone:** \_\_\_\_\_

Utah Department of Health, Office of Epidemiology, PO Box 142104, Salt Lake City, Utah 84114-2104

Telephone: (801) 538-6191, FAX: (801) 538-9923

**Date Submitted to UDOH:** \_\_\_\_\_